



## **Notice of Privacy Practice Receipt**

I acknowledge that I was provided with the Notice of Privacy Practice for Tidewater Orthopaedic:

Print Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Authorized Person (s) to Release Medical Information  
(Spouse, children, friend, anyone we can release information to about you)**

Print name of Person Representative: \_\_\_\_\_

Social Security Number of Representative (last four digits): \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Print name of Person Representative: \_\_\_\_\_

Social Security Number of Representative (last four digits): \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Refused to Sign Form: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Practice Employee: \_\_\_\_\_